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**CONFERENCE ABSTRACT****Proactive, Integrated Care within Sustainable and Transformation Planning**17<sup>th</sup> International Conference on Integrated Care, Dublin, 08-10 May 2017David Cochrane<sup>1</sup>, Mark Pierce<sup>2</sup>

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In December 2015, the NHS shared planning guidance 16/17 – 20/21 outlined a new approach to help ensure that health and care services are built around the needs of local populations. This aimed at delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency. The 3 CCGs collaborating in the Leicester, Leicestershire and Rutland Footprint serve a population of around 1 million which is one of the most culturally and ethnically diverse in England. Our service capacity encompasses 7 acute hospitals and 8 community hospitals serving patients from 146 primary care practices and combined annual health and social care budget of £.2.12 billion.

The Leicestershire and Rutland Sustainability and Transformation Plan (STP) is based on a whole population management approach in turn informed by analytics drawn from the Johns Hopkins Adjusted Clinical Groups (ACGs) case-mix and risk-stratification system. We are also building on our experience using the Better Care Fund (BCF) to extend our out-of-hospital services which are fully integrated with primary and community care, social services, mental health and the voluntary sector. Under the BCF, the priority was to strengthen our reactive, rapid response services to create viable alternatives to hospital for patients in urgent need. These are now showing good outcomes in avoiding hospital usage.

However, the ACG analytics has now identified some 23% of the population or 230,000 people who might form a clinically relevant cohort for a variety of interventions by Integrated Health and Social care teams centred around GP practices. Many would benefit from more pro-active services, utilising viable intervention pathways offered earlier in their condition trajectories. These interventions range from more anticipatory care coordination for high-risk patients, supportive self-care and empowerment through health coaching for early diagnosis patients, pre-diagnosis assessment through to public health initiatives which strengthen community capacity to promote healthier lifestyles for individuals.

In this presentation, we set out our challenges and objectives, document our progress to-date in integrated care against the triple-aims outcomes framework, and explain the detailed population needs identified by the ACG analytics, We will then set out the second phase of our integrated care transformation programme and share the findings of some early pilot work which we intend to inform this next , critical stage of development.

Cochrane: Proactive, Integrated Care within Sustainable and  
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